STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
R. KEVIN CLINTON
COMMISSIONER

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Annual Report on Group Employer Market Effects on HMOs as a Result of Increased Flexibility in Cost-Sharing Under MCL 500.3515

May 2011

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Determination

For the calendar year ending December 31, 2010, the Commissioner concludes that:

a) Greater copayment and coinsurance levels allowed under PA 306 of 2005 (PA 306) have not increased the number of employers who have contracted for health maintenance organization (HMO) services.
b) Greater copayment and coinsurance levels allowed under PA 306 have not increased the number of enrollees in the HMO employer group health benefit market.
c) Health maintenance organizations have taken advantage of the flexibility of cost-sharing limits with the introduction of innovative products to create a market that is appealing to employers.
d) Compared to 2009; there was an overall increase in the HMO employer group market in 2010.
e) Employers are shopping for different coverage plans with an interest in plans that include increased employee cost sharing, as a result of the economic downturn.

Based on the above conclusions that are supported by the data and findings in this report, the Commissioner has determined that greater copayment and coinsurance levels allowed by the amendatory act that provided greater flexibility to HMOs in this area have not directly increased the number of employer groups and enrollees receiving HMO services. However, HMOs have been developing products that take advantage of the flexibility in cost-sharing afforded by enactment of PA 306. The overall increase in employer group business may be caused by a variety of reasons but PA 306 has permitted HMOs to develop broader product options, from which employers can choose.

R. Kevin Clinton
Commissioner

5/25/11
Date

Office of Financial and Insurance Regulation

Historically, government regulated insurance, securities, and financial institutions (banks, consumer finance companies and credit unions), separately. A Depression-era federal law known as the Glass Steagall Act (adopted in response to the bank failures following the 1929 stock market crash) specifically prohibited a bank from offering securities and insurance products or engaging in commercial banking. The federal Financial Services Modernization Act of 1999, also known as the Graham Leach Bliley Act (GLBA) repealed the Glass Steagall Act barriers and allowed financial services holding companies to engage in any activity financial in nature so long as it did not cause a safety or soundness issue to the overall financial system.

With changing complexities in insurance, banking and securities, the old-fashioned regulatory model could not keep pace with the marketplace. Michigan became the first state to coordinate the regulation of insurance, financial institutions and securities into one governmental agency, under a single Commissioner, consistent with financial services modernization. Effective April 2000, the Office of Financial and Insurance Services (OFIS) was created by executive order to consolidate the bureaus of Insurance and Financial Institutions, and the Securities Division of the former Corporations, Securities and Land Development Bureau. The creation of OFIS allowed Michigan regulators to become adept at interpreting and regulating complex financial service entities that had not existed previously.

On April 16, 2011, Governor Rick Snyder appointed R. Kevin Clinton as commissioner of the Office of Financial and Insurance Regulation (OFIR), previously known as OFIS. As his first priority, Commissioner Clinton will make sure consumers are protected by ensuring financial institutions are sound and will lead the effort to eliminate burdensome regulations that are preventing the industry from growing.

Today, OFIR is responsible for the regulation of Blue Cross Blue Shield of Michigan, 25 HMOs, 114 state chartered and savings banks, approximately 171 domestic and 1,458 foreign insurance companies, 202 credit unions, 1,778 investment advisers, 1,969 securities broker-dealers, 6,172 consumer finance lenders, 194,835 insurance producers, and 131,194 securities agents, 9,214 investment advisor representatives, 3,958 mortgage licensees and registrants, 656 deferred presentment companies, and 2,387 other consumer finance-related entities. The OFIR licenses, registers, or charters these entities, conducts safety, soundness, and compliance examinations, and protects and educates Michigan consumers of financial services. Through adaptability and consumer communication, the Commissioner and staff of the OFIR strive to be the preeminent financial services regulator in the United States.

Introduction

During the 2005-2006 legislative session PA 306 was passed. The Act amended the Michigan Insurance Code, specifically MCL 500.3515, in part, to eliminate the requirement that copayments under a Health Maintenance Organization (HMO) contract be nominal. Previously, an HMO could have contracts that required copayments for *specific* health maintenance services but copayments had to be nominal for *basic health services.* Basic health services include: physician services, including consultant and referral services by a physician, other than psychiatric services; ambulatory services; inpatient hospital services, other than those for the treatment of mental illness; emergency health services; outpatient mental health services, not fewer than 20 visits per year; intermediate and outpatient care for substance abuse; diagnostic laboratory and diagnostic and therapeutic radiological services; home health services; and preventive health services.

Under PA 306, HMO contracts were permitted to include copayments stated as dollar amounts, and coinsurance stated as percentages, for the cost of services. Coinsurance for basic health services, excluding deductibles, could now be up to 50% of an HMO's reimbursement to an affiliated provider, but could not be based on the provider's standard charge for the service.

Public Act 306 requires the Commissioner to make an annual determination as to whether the greater copayment and coinsurance levels allowed by the Act have increased the number of employers who have contracted for HMO services, as well as the number of HMO enrollees. Public Act 306 requires the consideration of the following elements:

- Information and data gathered from HMOs regarding the effects of the greater copayment and coinsurance levels allowed by the bill.
- Information and data provided by employers who employ Michigan residents.
- Any other information that the Commissioner considers relevant.

Data Collection

Data was collected and analyzed from two Michigan-specific reporting forms, FIS 0322 and FIS 0323. Michigan requires all insurers with any type of accident and health authority under the Michigan Insurance Code to submit Michigan form FIS 0322. On the FIS 0322, carriers report the number of policies in force, member months, number of lives insured, direct premiums written, and direct losses paid. Data from the FIS 0322 is used to show the HMO market trend from 2002 through 2010.

The FIS 0323 is a reporting form specifically designed for HMOs to report employer health business as a result of enactment of PA 306. On the FIS 0323 HMOs report changes in commercial employer groups and enrollees in the two prior years.

This report also relies on information and data provided by Michigan employers as published in the Kaiser Family Foundation and Health Research & Educational Trust Employer Health Benefits 2010 Annual Survey.

Data Analysis

Three HMOs, Health Alliance Plan of Michigan, Priority Health, and Total Health Care USA, Inc., reported an increase in employer group business; Priority Health and Total Health Care USA, also reported an increase in the number of commercial enrollees, as did Grand Valley Health Plan. Health Alliance Plan reduced its number of commercial enrollees, in spite of its increase in employer groups. The increase of 90 employer groups and 5,620 enrollees is attributed to the ability of HMOs to design plans with higher cost sharing levels. Table 1a below, compares the employer group market experience between 2009 and 2010 as reported on the FIS 0323.

Table 1a Employer Group Market 2009 – 2010

	Commercial Employer Groups					Commercial Enrollees				
Health Plan	9/30/2009	9/30/2010	Change	% Change	Increase Due to Law Change	9/30/2009	9/30/2010	Change	% Change	Increase Due to Law Change
Blue Care Network of Michigan	7,279	6,757	-522	-7%	0	526,616	477,599	-8,505	-2%	0
Grand Valley Health Plan	118	107	-11	-9%	0	6,130	6,299	169	3%	0
Health Alliance Plan of Michigan	1,187	1,216	29	2%	0	360,846	341,968	-18,878	-5%	0
Health Plus of Michigan, Inc.	570	520	-50	-9%	2	63,773	59,897	-3,876	-6%	52
Paramount Care of Michigan, Inc.	291	239	-55	-19%	0	4,964	3,961	-1,003	-20%	0
Physicians Health Plan of Mid-Michigan	465	360	-116	-24%	0	40,985	35,614	-5,371	-13%	0
Priority Health	8,466	9,673	1,207	14%	35	352,334	377,320	34,986	10%	2,835
Total Health Care USA, Inc.	407	469	62	15%	53	17,692	23,033	5,341	30%	2,733
	18,783	**19,341**	**544**	**-37%**	**90**	**1,373,340**	**1,325,691**	**2,863**	**-3%**	**5,620**

Table 1b illustrates the five year trend in the HMO employer group market. The initial period reflects the date PA 306 went into effect (December 21, 2005) compared to the data reported for the 2010 HMO market experience. Table 1 b shows that overall; HMOs are attributing an increase of 119 employer groups to the greater flexibility of cost-sharing limits. Even though enactment of PA 306 has increased the interest of some employers, there has only been a 1% increase in commercial employer groups with a loss of 7% of enrollees since 2005.

Table 1b – 5 Years After PA 306

	Commercial Employer Groups					Commercial Enrollees				
Health Plan	12/31/2005	9/30/2010	Change	% Change	Increase Due to Law Change	12/31/2005	9/30/2010	Change	% Change	Increase Due to Law Change
Blue Care Network of Michigan	7,450	6,757	-693	- .09%	0	430,120	477,599	47,479	11.00%	0
Grand Valley Health Plan	269	107	-162	-60%	0	15,546	6,299	-9,247	-59%	0
Health Alliance Plan of Michigan	2,412	1,216	-1,196	-50%	29	453,837	341,968	-111,869	-25%	-18,878
HealthPlus of Michigan, Inc.	819	520	-299	-37%	2	83,590	59,897	-23,693	-28%	52
Paramount Care of Michigan, Inc.	255	239	-16	-6%	0	7,081	3,961	-3,120	-44%	0
Physicians Health Plan of Mid-Michigan	1,219	360	-859	-70%	0	72,755	35,614	-37,141	-51%	0
Priority Health	6,847	9,673	2,826	41%	35	370,199	377,320	7,121	2%	2,835
Total Health Care USA, Inc.	310	469	159	51%	53	9,152	23,033	13,881	152%	2,733
	19,581	**19,341**	**219**	**1%**	**119**	**1,442,280**	**1,325,691**	**-107,943**	**-7%**	**-13,258**

Health maintenance organizations have the opportunity to provide narrative information relative to marketing. The following section provides the narrative responses received on the FIS 0323 for 2010:

- Blue Care Network of Michigan has no new group employer plans with increased annual copayment and coinsurance levels.

- Grand Valley Health Plan did not create or use any new products that exceed the previously approved limits of $3000/individual and $6000/family.

- Health Alliance Plan's (HAP) value plans increased membership since 2006 from 2811 in 2006 to 24,879 members in 2010. In 2010, HAP introduced two new riders where annual copayment and coinsurance levels increased. The optional riders offer $2000/individual and $4000/family deductibles with $5000 individual and $10,000/family out of pocket maximums.

- HealthPlus of Michigan, Inc. launched its SaverPlus HMO plans in September 2008. Five employer groups are currently covered under the SaverPlus plans with higher deductibles. Of the five groups covered under the higher deductible plans, two had previous health care coverage under a non-profit health care corporation. The high deductible plans have an integrated health reimbursement account to help the employer offset some of the employees' out of pocket costs.

- Paramount did not provide plan details for this reporting period.

- Physicians Health Plan of Mid-Michigan did not introduce any new plans in 2010 that had higher copayment or coinsurance levels.

- Priority Health did not introduce any new plans in 2010 that have higher copayment and coinsurance levels. Although no new high cost sharing products were introduced in 2010, Priority Health increased its employer group business by 35; three employer groups had previous coverage under a nonprofit health care corporation, one had previous coverage through a traditional insurer, three had been covered through a Preferred Provider Organization (PPO), two had been self-insured. The previous health care coverage providers for the remaining 26 employer groups were not reported to Priority Health. Identification of the previous health care coverage provider is not required under Priority Health's group application process.

- Total Health Care has made no changes to its products where the annual copayment and coinsurance levels have increased during this reporting period. Products are redesigned and modified annually to respond to the wants and needs of the customers. The current trend is to increase annual

copayment and coinsurance levels to reduce cost increases to the employer groups. The increase of 53 employer groups during the 2010 reporting period, include 50 that were previously covered by a nonprofit health care corporation, 9 that were covered by traditional insurers, 12 were covered by preferred provider organizations (PPO), and 2 were self-insured.

As the responses above indicate, HMOs took advantage of the flexibility in cost-sharing soon after enactment of PA 306 by developing products that give employers a variety of cost-sharing options; however, no major product changes have been made during the 2010 reporting period.

The data from the FIS 0322 provides a broader picture of HMOs in the group market. From 2002 through 2010, there was a decline in HMO activity in the large and small group employer health markets. In 2002 there were 27 HMOs writing group coverage; in 2010 there were 19, although this is slightly higher than 2009. The number of lives in the group HMO market has fluctuated throughout the same period, but in 2002 there were 1,572,982 enrolled lives and in 2010 there were 1,289,936 lives. A common measure used by HMO entities is that of "member months." A member month is a data term meaning the actual number of members the HMO had in a particular month. In 2002 the reported member months for HMOs was 18,430,464 and in 2010 it was 15,290,569. The tables below illustrate some aspects of the group employer market from 2002 through 2010.

Table 2a HMOs reporting group business

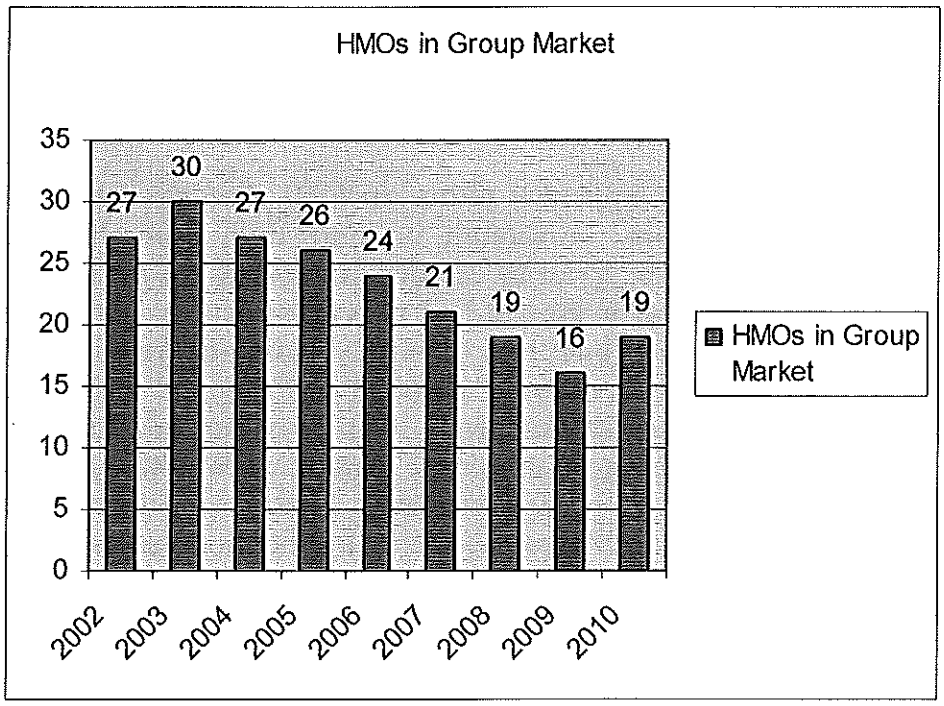


Table 2b HMOs writing small group business

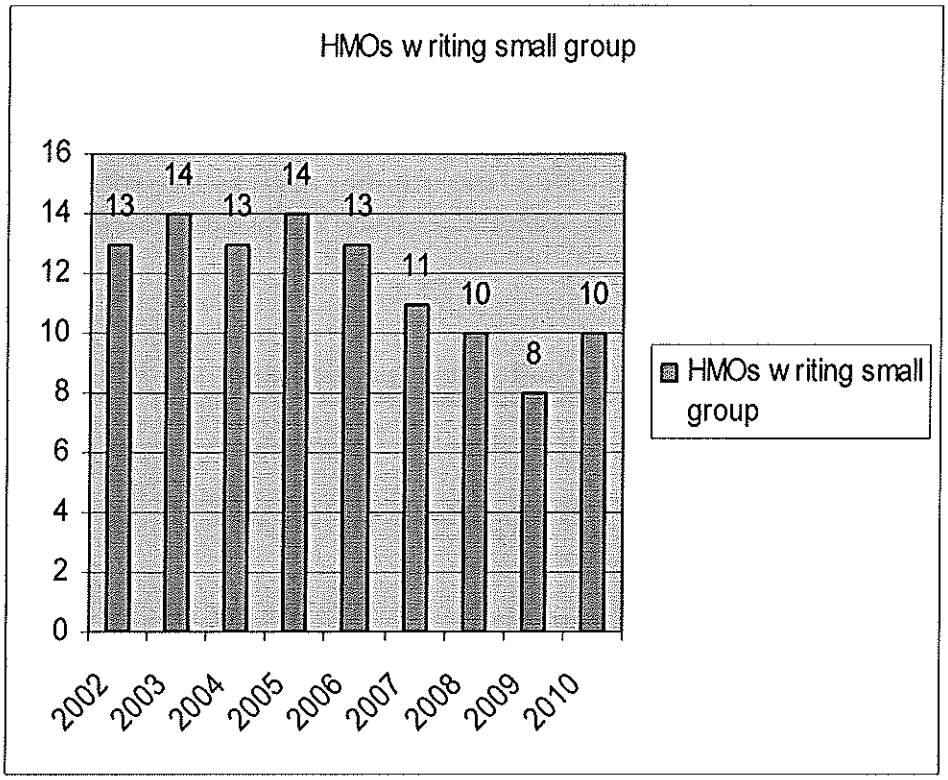
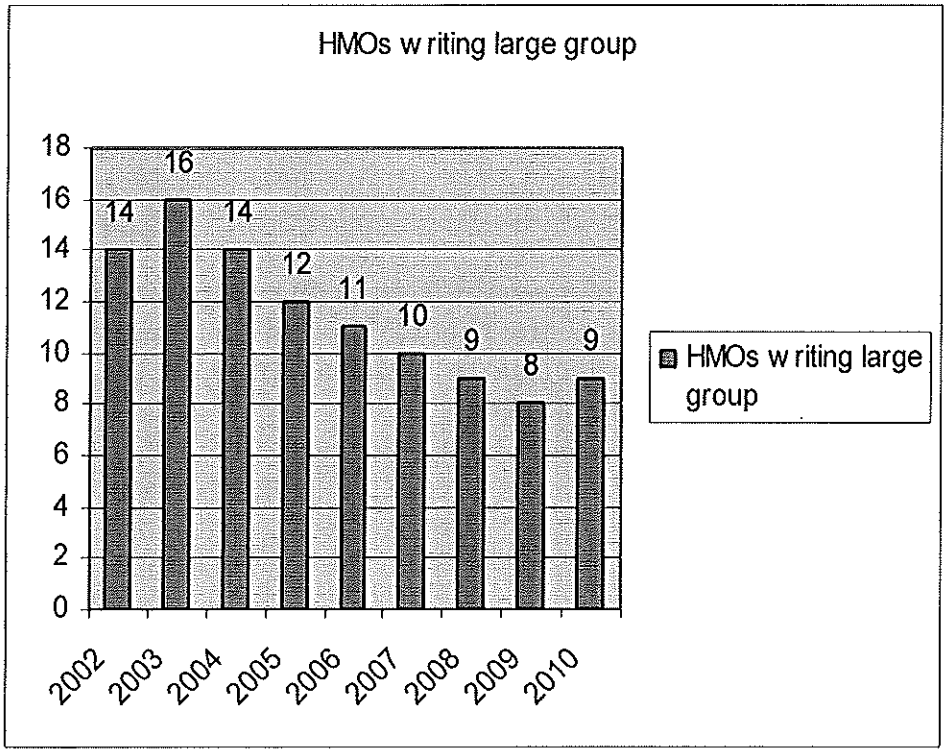


Table 2c HMOs writing large employer group



As can be seen in the tables above, HMOs writing large employer groups have shown a steady decline since 2002, although 2010 shows a slight increase. The small group market appears to have remained stable until 2005, when a steady decline began; the year PA 305 was enacted.

Table 2d illustrates the number of enrollees in HMOs from 2002 through 2010. Aside from the large spike in enrollments in 2003, the number of lives has remained relatively steady with a gradual decline in enrollees since 2006 and 2007, after enactment of PA 306.

Table 2d: Number of enrollees, including dependents as reported on the FIS 0322

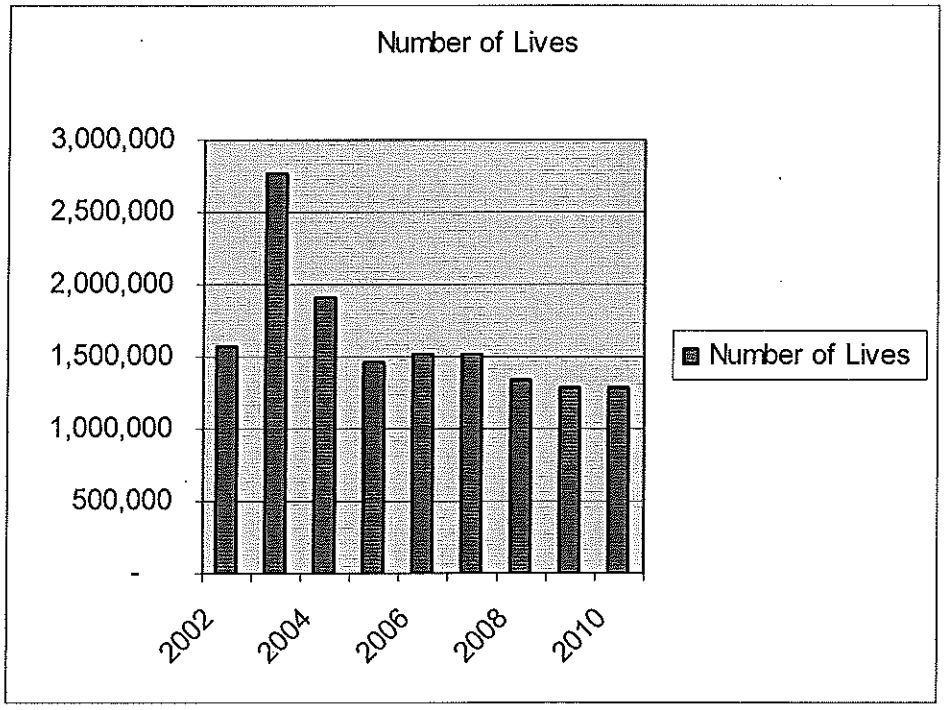
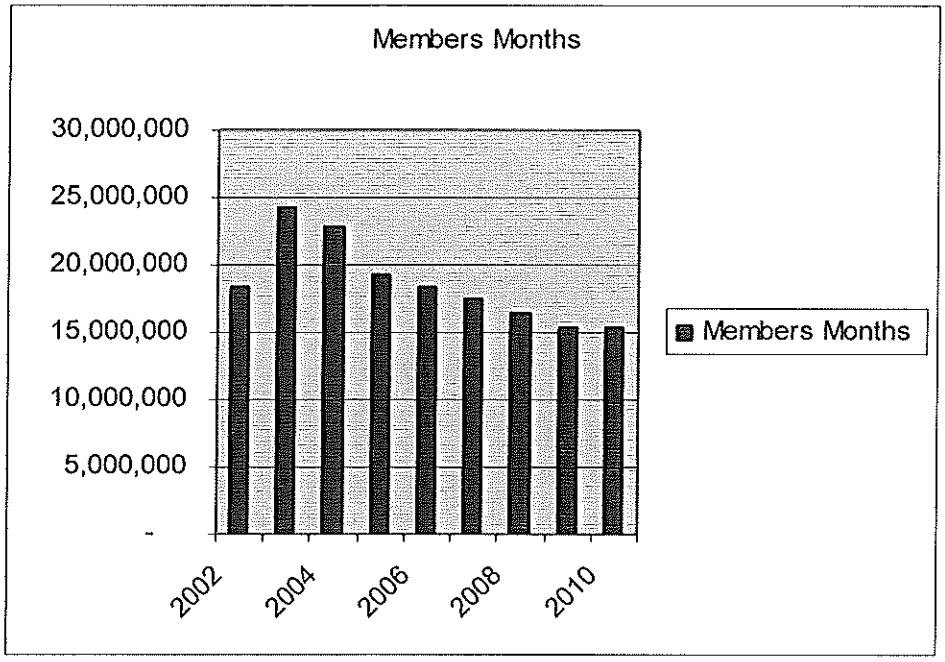


Table 2e below, provides an illustration of measurement using member months. Again, this is the actual number of members the HMO had in a particular month. This measure shows a steady decline in HMO activity in the large and small employer group health benefit market.

Table 2e: Data of Member Months as reported on the FIS 0322



The data presented in these tables draws one to conclude that greater copayment and coinsurance levels that were introduced through PA 306 did not increase the number of employers who have contracted for HMO services and it did not increase the number of HMO enrollees.

The data collected from the FIS 0322 and FIS 0323, as illustrated in the market trend tables, do not show if there has been a greater presence of HMOs in the individual market or of that in the government programs markets. They also do not provide a cause for the decline in the HMO employer group market. However, it does indicate that enactment of PA 306 has not, as of 2009, had a large impact on the employer group market.

The Kaiser Family Foundation and Health Research & Educational Trust Employer Health Benefits 2010 Annual Survey findings indicates that 13% of employers believe higher employee cost sharing is an effective strategy for health insurance cost containment; 27% believe it is not at all effective. Despite employers' perception of the ineffectiveness of increased cost sharing to control costs, 30% of small firms and 38% of large firms reported making health plan changes that include increased employee cost sharing; reported as a result of the economic downturn.

Whether employers were looking for plans with increased cost sharing, lower premiums, or better disease management programs, 60% of employers reported that they had shopped for a new plan or carrier in 2010; 27% changed carriers and 33% change health plan types in 2010.